STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory Indiana

Citation	Condition or Requirement
1906 of the Act	State Methodology on Cost Effectiveness of Employer-Based Group Health Plans

Indiana's formula for determining the cost-effectiveness of an insurance plan compares the **purchase cost** of the available insurance coverage to the estimated **average annual Medicaid expenditures** for the recipient to be covered by the plan. The purchase cost is computed by totalling the dollar amounts of the annual **premium**, **deductible**, **coinsurance**, **administrative cost**, and **non-covered services**. [See definitions below for each of the highlighted factors.] The average annual Medicaid expenditure is estimated using State-developed tables of historical expenditure data per recipient type (based on demographics such as aid category, age, sex, institutional status, high cost diagnosis).

Since estimated annual Medicaid expenditures are based on averages and actual individuals' expenditures vary widely across the range from which the average is calculated, the State will ensure a higher probability of overall cost-effectiveness by paying the premium only when the estimated average annual expenditure is greater than or equal to twice the purchase cost*. For example:

purchase cost = $1500
estimated expenditures must be ≥ $3000

Definitions:

1. **Average Annual Medicaid Expenditure** - the average annual benefit dollars Medicaid expects to expend on behalf of the recipient (based on expenditures for similar individuals)

2. **Premium** - the fee Medicaid must pay to obtain the available insurance coverage for one year

* In cases where the individual is known to have a high cost diagnosis, the twice-the-cost criterion will not be applied.

3. **Deductible** - the annual policy-specific deductible amount

4. **Coinsurance** - the amount of any copayments/contributions the insured is required to pay (pro-rated based upon the number and types of services the insured is expected to receive in a year according to State-developed, policy-specific tables)

5. **Administrative Cost** - the annualized administrative cost of ongoing operation of the health insurance premium payment program on a per recipient basis

6. **Non-Covered Services** - the annual cost of services expected to be paid by Medicaid which are not covered by the available insurance policy or for which policy benefits are exhausted

7. **Purchase Cost** - the sum total of the dollar amounts for items 2. through 6. above